The New Mexico Clinical Prevention Initiative: A Statewide Prevention Partnership

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SYNOPSIS

The New Mexico Department of Health and the New Mexico Medical Society invited organizations to participate in an initiative to promote clinical preventive services. The Clinical Preventive Initiative (CPI) focuses on the following interventions based on burden of illness, preventability of the condition, cost, current level of services, availability of leadership, and programmatic support: adult pneumococcal vaccination, tobacco use prevention and cessation, mammography screening, colorectal cancer screening, healthier weight, screening and treatment for chlamydia and gonorrhea, screening and intervention for problem drinking, childhood immunization, and prevention of unintended pregnancy. Specific workgroups plan and implement interventions directed at New Mexico medical practices, practitioners, and health-care systems. Several state measures suggest effectiveness of CPI efforts.

CPI is a successful public-private collaboration providing an active forum for statewide clinical prevention policy development, an effective mechanism to achieve greater awareness of prevention and improved delivery of preventive services.

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Disease prevention efforts in the U.S. have led to remarkable improvements in quality of life and life expectancy. In the 20th century, communicable diseases ceded their place as the leading causes of death to chronic diseases, which, in turn, have also trended downward in response to improved prevention and treatment. Despite these considerable accomplishments, only a small fraction of the health-care budget is spent on population-based prevention[1] and many in the United States do not receive recommended preventive services.[2]

New Mexico faces unique challenges and opportunities for improving clinical preventive services. New Mexico has the second-highest rate of medically uninsured, inadequate prenatal care and children in poverty.[3] Due to the large size and rural nature of the state, many residents must travel long distances for care, leading to decreased access to certain services and/or treatment choices for many New Mexicans. For example, New Mexico women with early-stage breast cancer treated with breast-conserving surgery are less likely to receive postoperative radiation therapy the farther they live from radiation treatment centers.[4] Racial and ethnic diversity is an additional challenge to improving prevention services in New Mexico. With a population that is 43% Hispanic and 10% Native American, New Mexico is one of the most racially and ethnically diverse states in the U.S. These groups may differ in patterns of disease burden or respond to prevention efforts in a culturally distinct manner. For example, the prevalence of diabetes in Native Americans and Hispanics in New Mexico is three times and two times higher than in non-Hispanic whites, respectively.[5] On the other hand, New Mexico has enjoyed relatively low rates of cancer and cardiovascular mortality due in part to lower smoking rates, particularly in Native Americans.[6] Finally, New Mexico has the highest injury mortality rate in the U.S., much of it alcohol related.

New Mexico has a close-knit provider community despite the large geographic area covered by the state. The close association of many providers in the state allows for more effective communication that emphasizes public service and facilitates new initiatives perceived as beneficial for New Mexicans. This article describes the establishment of the Clinical Prevention Initiative (CPI). CPI is a public-private prevention-focused collaboration involving a spectrum of health-related organizations that serves as a forum for statewide professional education and policy development for improving clinical preventive services (CPS) in New Mexico.

HISTORY OF CPI

In 1999, a family practitioner in rural New Mexico who has a special interest in clinical prevention, and who is also an active member of the New Mexico Medical Society (NMMS), noted an article featuring CPS in the New Mexico Department of Health's (NMDOH) monthly *Epidemiology Report*.[7] He met with the author of the article to discuss the need for improved use of CPS and together they developed a strategy to accomplish this goal. In early 2000, a small workgroup of key decision-makers was formed with representation from the NMMS and the NMDOH—a link facilitated by the existence of a formal NMMS-NMDOH Liaison Group. This workgroup identified and contacted partners in health-related organizations across New Mexico. Most expressed support for the initiative and came to the planning meeting. Initial meetings focused on developing prevention priorities for New Mexico. The decision to concentrate on CPS led to a consensus to name the group the Clinical Prevention Initiative, or CPI. The founding members, who formed the CPI steering committee, focused on three initial prevention topics: adult pneumococcal vaccination, tobacco use, and mammography screening. These topics—identified by the group as having national and statewide importance—were chosen for practical reasons as they represented three different prevention modalities: immunoprophylaxis, counseling/pharmacotherapy, and screening. Considered together, they promised relevance of CPI to all primary-care specialties. The first topic, pneumococcal vaccination, offered a quick, noncontroversial intervention. The second topic, tobacco use, carried the promise of intervention resources from the New Mexico master tobacco settlement agreement. Finally, mammography screening fit well with recent NMDOH initiatives. Three topic-specific workgroups were formed, and the NMDOH committed start-up funding for administrative support, which was to be located within the NMMS.

Subsequently, a representative from the Centers for Disease Control and Prevention (CDC)—who was collaborating with Partnerships for Prevention (www.prevent.org), a nonprofit organization involved in developing methods to prioritize CPS—was invited to address the steering committee. He discussed an algorithm for prioritizing preventive services recommended by the United States Preventive Services Task Force (USPSTF) that combined burden of illness, cost-effectiveness, and preventability that appeared well-suited for the planning stages of the CPI.[8] This prioritization report has been recently updated using more recent USPSTF recommendations and new data available since 2001.[9] The selection by the CPI steering

committee of the next three topics—colorectal cancer screening, screening and treatment of chlamydia and gonorrhea, and problem drinking—was influenced by the Partnership prioritization process in conjunction with available workgroup leadership and financial support within the NMDOH. An additional consideration for the inclusion of chlamydia/gonorrhea and colorectal cancer screening was their inclusion as Health Employer Data and Information Set (HEDIS) measures that managed-care organizations are encouraged to collect to track their performance. Three more topics guided by the Partnership's prioritization process—childhood immunization, promotion of healthier weight, and unintended pregnancy prevention—were selected on the basis of relevance in New Mexico, advocacy by steering committee members, and the potential for external resources to carry out interventions.

Membership, growth, and structure

The CPI has grown from the core group of founders to more than 175 individual and 30 organizational members (Figure 1). Workgroups have grown in number from three to nine in five years. Initially, the CPI had a simple structure in which members from all workgroups participated in quarterly steering committee meetings led by cochairs from NMMS and NMDOH. Decisions were made by consensus at steering committee meetings or at the workgroup level.

As the number of workgroups, organizational partners, and initiatives grew, the need for a more formal and consistent decision-making process was identified. Governance guidelines were adopted that called for a smaller executive committee to promote timely and efficient decision-making. To ensure that CPI efforts were compatible with the missions and values of the two founding organizations, NMMS and NMDOH, the executive group was designed with four ex-officio positions: cochairs from NMMS and NMDOH, the NMMS President, and the NMDOH Chief Medical Officer; three other positions are filled by nominees of the steering committee. The steering committee continues to meet quarterly to review progress of, and provide input to, individual workgroups, to consider proposals for developing new topics and interventions, to recommend CPI policy positions, and to identify resources to support workgroup efforts.

The executive committee communicates on an ad hoc basis (via e-mail, conference calls, or in-person meetings) to set policies, adopt positions, make decisions regarding steering committee or workgroup proposals, and troubleshoot CPI issues. Governance guidelines are posted along with general program descriptions and workgroup materials on the CPI page on the NMMS website (www.nmms.org).

As each clinical prevention topic is adopted through consensus vote by the CPI, steering committee members volunteer or are recruited to participate in workgroups based on expertise, program affiliation, or interest. Each workgroup selects a chair or cochairs and frequently includes the person(s) who proposed

Figure 1. New Mexico Clinical Prevention Initiative organizational membership, 2006

Type of organization	*Organization*
State government	New Mexico Department of Health[a] New Mexico Human Services Department, Medical Assistance Division (Medicaid)
Professional organization	New Mexico Medical Society[a]
Specialty society	New Mexico Chapter, American Academy of Family Physicians New Mexico Academy of Physician Assistants New Mexico Pediatric Society New Mexico Society for Respiratory Care New Mexico Primary Care Association New Mexico Dental Association
Private managed-care organization	Blue Cross Blue Shield of New Mexico Lovelace Health Plan Presbyterian Health Plan Molina Health Care
Private foundation	Community Voices/American Legacy Foundation McCune Charitable Foundation
Educational institution	University of New Mexico Health Sciences Center New Mexico Tumor Registry
Federal government	New Mexico Veterans Affairs Health Care System Indian Health Service
Advocacy organization	New Mexicans Concerned About Tobacco American Cancer Society American Lung Association Policy Matters
State coalitions	Chronic Disease Prevention Council New Mexico Healthcare Takes on Diabetes New Mexico Immunization Coalition New Mexico Influenza Vaccine Consortium
Health quality improvement	New Mexico Medical Review Association
Research organization	Lovelace Clinic Foundation RIOS Net (Research Involving Outpatient Settings) Behavioral Health Research Center

[a]Founding and cosponsoring organizations

the workgroup. Proposing a new workgroup typically includes a review of the evidence for relevant clinical prevention strategies and an analysis of barriers to implementation of "best prevention practices." The person proposing the workgroup then presents this information to the CPI steering and executive committees for approval and shows that funding has been identified for its support. Once the newly formed workgroup convenes, its membership develops an intervention plan and supervises its implementation. Characteristic activities include materials appropriate for a practitioner audience, consultation and facilitation of solutions for coverage, and payment problems (Figure 2).

Funding

The NMDOH provides most of CPI's funding, but it is supplemented by a foundation grant for one of the workgroups and in-kind services from the University of New Mexico. Originally, the NMDOH programs (cancer, tobacco, immunization, etc.) individually funded CPI workgroups whose activities were specific to those programs. NMDOH funding for the tobacco use prevention and cessation workgroup derived primarily from state general funds appropriated for tobacco control, which represented the majority of CPI funding and has served to build much of the CPI infrastructure at the NMMS. For the last two years, the NMDOH consolidated funding, originating mainly from federal sources, into a formal Request for Proposal (RFP) process resulting in more efficient and timely disbursement of funds to the participating CPI workgroups.

Leadership

CPI's growth and success result from the high level of motivation and commitment of health professionals and organizations from the public and private health communities of New Mexico to increase prevention services in health-care delivery. Critical to this success has been the leadership and commitment of the cofounding "physician champion" from the private sector, who is an active member of the NMMS. His clinical and health administrative experience in New Mexico have helped shape important components of CPI, such as the affiliation with the New Mexico Medical Society and formation of the Payer Liaison Group. Leadership from the NMDOH included building a partnership with the private sector as a powerful mechanism to promote a prevention agenda and supporting this partnership by committing funding for its support. NMDOH leadership in CPI has also driven the development of Governance Guidelines, which have facilitated workgroup formation and functioning and overall CPI organization and sustainability. Finally, the sustainability of each workgroup has hinged on individuals stepping forward to lead the workgroup. With the exception of the salaried positions created at the NMMS, volunteers from all sectors of the New Mexico health-care system have maintained the CPI and all workgroup activities. The dedication of these volunteers and their role in sustaining CPI may be attributable to CPI's visibility and acceptance by all major health-related organizations.

ROLE AND ACCOMPLISHMENTS OF THE CPI

The CPI has become a popular and respected forum for providers, payers, and the public health community of New Mexico to discuss prevention policy and make suggestions for translating new research into policy. For example, the Chlamydia and Gonorrhea Screening and Treatment workgroup recently requested that CPI support expedited partner therapy (EPT), in which medication is offered to patients with chlamydia and gonorrhea to give to their sex partners—a practice supported by recent randomized trials and CDC recommendations.

The CPI executive committee reviewed the request and supporting data and subsequently drafted a resolution regarding EPT for sexually transmitted diseases (STDs)—consistent with the most current version of CDC and NMDOH guidelines—which was passed by the NMMS House of Delegates in May 2006. The proposal was then forwarded to the New Mexico Medical Board, which met in mid–2006 and agreed to revise the New Mexico Medical Practice Act regulations on medical ethics (section 16.10.8) to allow for exempting treatment of STDs in accordance with guidelines from the Department of Health. The change to the Medical Practice Act went into effect on January 5, 2007.

Research is encouraged by CPI to address knowledge gaps and increase effectiveness of workgroups. For instance, the Colorectal Cancer Screening workgroup conducted a survey of New Mexico gastroenterologists, which identified additional potential colonoscopic capacity in the state, as well as limitations to an endoscopic-only approach to meeting population screening goals.[10]

CPI quarterly steering committee meetings are well attended with representation from most health-related organizations in New Mexico. This forum is expanded by CPI's role as a clearinghouse for speakers for professional meetings occurring throughout the state. These include the New Mexico Chapter of the American Academy of Family Physicians, the American College

Figure 2. Summary of Clinical Preventive Initiative (CPI) workgroup material and activities, New Mexico, 2000–2005[a]

Workgroup	*Activities*
Adult pneumococcal vaccination	Fact sheet including information on discounted vaccine purchasing and coding—2001, 2002, 2003, 2004, 2005, and 2006
Tobacco use avoidance and cessation	• Comprehensive provider workbook accredited for a maximum of eight category 1 PRA of the AMA, eight respiratory therapy credits, and six continuing dental education credits • Expert speakers on tobacco cessation counseling and how to integrate it into your office system • Participation in Minimum Coverage for Tobacco Cessation Treatment—insurance regulation requiring that any insurance policy providing maternity benefits must provide tobacco cessation treatment
Mammography screening	• Professional educational material posted on CPI website and distributed directly to providers: — Breast Imaging and Reporting Data System [BI-RADS] article — BI-RADs assessment category summary posted on CPI website — Algorithms on breast mass and micro-calcification evaluation — Frequently Asked Questions sheet for patients • Follow-up of Abnormal CBE and Mammographic Findings—video-based self-study packet accredited for a maximum of three category 1 PRA of the AMA
Colorectal cancer screening (CRC)	• Colorectal Cancer Screening in New Mexico: A Handbook for Health Care Providers, 2002 and 2004. Accredited for a maximum of four category 1 PRA of the AMA • Survey of endoscopic providers in the state, the results of which are published in the CDC online journal, *Preventing Chronic Disease: Public Health Research, Practice, and Policy*. The article is entitled "New Mexico's Capacity for Changing Prevalence of CRC Screening Colonoscopies" • House Joint Memorial 74—insurance coverage clarification of CRC screening • Dialogue for Action: Capacity Building for CRC Screening in the Southwest, 2003 and 2005 • Expert speakers on CRC screening • Press conference on CRC screening and CPI handbook
Chlamydia and gonorrhea screening and treatment	• Screening guide with diagnosis and treatment options • Frequently Asked Questions • Fact sheets for providers • Patient fact sheet • Expert speakers on chlamydia screening • Advocated for expedited partner therapy
Problem drinking screening and counseling	• Problem Drinking Screening and Counseling in New Mexico: A Handbook for Health Care Providers. Accredited for a maximum of four category 1 PRA of the AMA • Expert speakers on problem drinking screening and counseling
Childhood immunization	• Done By One program materials: — Bilingual Health Passports Immunization card — Bilingual brochures for parents — Bilingual posters of immunization schedule — Vaccine combination guide • New Mexico Statewide Immunization Information System (NMSIIS) brochure for providers and parents • Expert speakers on childhood immunization, Done By One, and NMSIIS • Focus groups at annual conferences
Healthier weight	• "Getting in Balance" materials — Bilingual exam/waiting room posters — Bilingual patient action plan brochures • Clinical algorithm addressing screening, prevention, treatment options, and maintenance for adult overweight and obesity • Quick Discussion Guide for adult weight counseling • Expert speakers on promoting healthier weight in clinical and community settings
Prevention of unintended pregnancy	• Provider information sheet on contraception options • Expert speakers on contraception

[a]Workgroups are listed in the order in which they were initiated.

PRA = Physician Recognition Award

AMA = American Medical Association

CDC = Centers for Disease Control and Prevention

of Physicians, the New Mexico Academy of Physician Assistants, the New Mexico Dental Association, and the New Mexico Society for Respiratory Care. During the 2005 New Mexico legislative session, the CPI was invited to present prevention options to the full New Mexico Senate on the three prevention priorities chosen by the governor of New Mexico—healthier weight, unplanned pregnancy, and childhood immunizations—that coincided with established CPI workgroups. Physician members presented an overview of each problem and explained how the CPI was addressing it in an educational forum that included Senate participation in an active question-and-answer session. CPI activities have been presented at seven national conferences and materials have been solicited from the CPI office by 13 states.

The CPI forum has also increased awareness by the NMMS and other clinician groups of the public health perspective, which has served to consolidate policies and positions supporting clinical prevention within the NMMS. Similarly, the medical directors and staff of the health plans in New Mexico are increasingly invested in preventive health, as demonstrated by their active participation in the CPI and health plan utilization of CPI materials to unify and simplify communication with participating practitioners. This engagement in CPI by the health plans has facilitated provider reimbursement, a critical factor to the enhanced delivery of CPS.

The CPI addresses barriers to reimbursement through a Payer Liaison Group comprised of senior coding and claims managers from each of the health plans, Medicaid, and Medicare. When a CPI workgroup requires input or offers recommendations on coverage or claims coding issues**,** it may send representatives to meet with or submit questions to the Payer Liaison Group. Information from the Payer Liaison Group is often included in materials developed by the CPI workgroup. For example, CPI was able to verify health plan coverage of billing codes for specific interventions, including: counseling and coordination of care time overrides for selection of evaluation and management codes (E and M codes); diagnostic codes related to promoting healthier weight and screening for problem drinking and intervention; and to determine reimbursable codes for tobacco cessation counseling. CPI was also able to remedy a coding inconsistency between Medicare Advantage plans that was a cause of rejected claims for pneumococcal vaccine administration.

Another essential component of prevention is establishing an evaluation plan and selecting appropriate indicators for that plan. Individual workgroups are tracking process and outcome indicators that may prove useful for determining CPI effectiveness (the Table). Several of these indicators suggest that CPI workgroups have made an impact on health. In 2003, in response to low state childhood immunization rates and the impression by providers of a drop-off in visits for well child care in the second year of life, the CPI Childhood Immunization workgroup introduced a more aggressive immunization schedule that consolidates the Advisory Committee on Immunization Practices (ACIP) recommendations into shorter time frames to accomplish full immunization by age one (Figure 2).[11] In the 2005 National Immunization Survey (NIS) conducted by CDC, the New Mexico rate for the cumulative vaccine series in children 19–35 months of age increased by 13.8% from 2002 to 2005 (the Table). New Mexico now ranks 36th in the U.S., up from 49th in 2002.[12] Practices using the Done by One program in New Mexico have shown improvement in their 4:3:1:3:3 coverage rate—a benchmark indicator used nationally by health authorities and health plans—when compared to practices not using the program. (Personal communication, Steve Nickell, PhD, Director, New Mexico Immunization Program, November 2005.) Based on CPI's experience, the Done by One program has been adopted by Oklahoma and Louisiana.

The CPI Tobacco Use Avoidance and Cessation workgroup's activities include extensive provider training and participation in the expansion of insurance coverage for tobacco use cessation services[13] (Figure 2). The NMDOH Tobacco Use Prevention and Control Program reported that the percentage of New Mexico smokers who visited a health-care provider in the past year and were advised to quit smoking increased from 49% in 2001 to 68% in 2003[14] (the Table). Though this change cannot be directly or completely attributed to the CPI's activities, the emphasis placed by the Tobacco Use Avoidance and Cessation workgroup on provider education strengthens the argument for an association. Although modest, the apparent downward trend in prevalence of cigarette smoking from 23.6% in 2000 to 20.3% in 2004 may reflect an impact of tobacco use prevention and cessation efforts in New Mexico, including those of CPI (the Table).

The proportion of the population aged 50 and older screened for colorectal cancer increased from 46.8% in 2002 to 54.8% in 2004 using the combined measure of fecal occult blood testing (FOBT) in the past one year or having received endoscopic (flexible sigmoidoscopy or colonoscopy) in the last 10 years. This substantial increase suggests an impact of colorectal cancer prevention efforts, including those of the CPI Colorectal Cancer Screening workgroup (Figure 2 and the Table). Finally, the increasing proportion of young women

Table. Indicators for Clinical Preventive Initiative workgroups, New Mexico, 2000–2004[a]

Indicator (data source)	*Details*		*2000*	*2001*	*2002*	*2003*	*2004*
			Point estimate (95% CI)	*Point estimate (95% CI)*	*Point estimate (95% CI)*	*Point estimate (95% CI)*	*Point estimate (95% CI)*
Pneumococcal vaccination (BRFSS[a])	Adults aged 65+ who have had pneumococcal vaccine (percent)		NA[b]	62.7 (59.0, 66.6)	62.7 (59.3, 66.1)	63.9 (60.8, 66.9)	64.6 (61.8, 67.4)
Pneumococcal vaccination (Medicare)	Percent of NM Medicare beneficiaries who received pneumococcal immunization ever		30.9	31.2	32.2	33.6	NA
Tobacco cessation (New Mexico Adult Tobacco Survey—2001, 2003)	Percent of NM smokers who saw a health-care provider in the past year and were advised to quit		NA	49.0	NA	68.0	NA
Prevalence of cigarette smoking (BRFSS)	Percent of New Mexicans aged 18+ who reported smoking 100 lifetime cigarettes and reported smoking every day or some days		23.6 (21.8, 25.3)	23.8 (22.0, 25.5)	21.2 (19.7, 22.7)	22.0 (20.6, 23.3)	20.3 (19.0, 21.5)
Breast cancer screening—mammogram in past two years (BRFSS)	Percent of women aged 40+ who have had a mammogram in past two years		NA[b]	NA[b]	69.6 (67.2, 72.1)	NA[b]	69 (67.0, 71.1)
Colorectal cancer screening—fecal occult blood test (FOBT) or lower endoscopy (BRFSS)	Percent of adults aged >50 who have had FOBT in the last year or lower endoscopy (flexible sigmoidoscopy or colonoscopy in the last 10 years)		NA	NA	46.8 (44.5, 49.2)	NA	54.8 (52.8, 56.7)
Chlamydia screening (HEDIS)	Percent of chlamydia screening in women enrolled in five NM MCOs (aged 16–20 and 21–26)		NA	27.2/27.6	24.6/24.1	27.1/31.5	33.3/35.1
Problem drinking/binge drinking (BRFSS)	5+ drinks on an occasion in past month (percent)	Males	24.5	26.6	23.0 (20.7, 5.5)	23.7 (21.5, 25.9)	20.2 (18.2, 2.3)
		Females	7.7	5.6	6.4 (5.3, 7.7)	7.4 (7.4, 6.3)	6 (5.1, 7.1)
		Total	15.8	15.8	14.4 (13.1, 15.8)	15.3 (14.1, 16.6)	12.9 (11.8, 14.1)

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Table (continued). Indicators for Clinical Preventive Initiative workgroups, New Mexico, 2000–2004[a]

Indicator (data source)	*Details*		*2000* *Point estimate (CI)*	*2001* *Point estimate (CI)*	*2002* *Point estimate (CI)*	*2003* *Point estimate (CI)*	*2004* *Point estimate (CI)*
Childhood immunizations (National Immunization Survey: 2001–2005)	4:3:1:3:3 coverage rate (4+ doses of DTaP, 3+ doses of poliovirus vaccine, 1+ doses of any MMR, 3+ doses of Hib, 3+ doses of HepB) (percent)		64.5 (58.4, 70.6)	63.2 (57.7, 68.7)	64.6 (57.9, 71.3)	75.2 (68.4, 82.0)	83.5 (78.2, 88.8)
Healthier weight (BRFSS)	Percent overweight or obese by BMI ≥25	Males	63.1	65.8	63.5 (60.7, 6.2)	64.2 (61.7, 66.6)	63.9 (61.4, 66.3)
		Females	47.7	48.9	49.5 (47.2, 51.9)	49.2 (47.1, 51.4)	48.9 (47.0, 50.8)
		Total	55.4	57.2	56.4 (54.6, 58.2)	56.6 (55.0, 58.3)	56.2 (54.6, 57.7)
Prevention of unintended pregnancy (PRAMS)	Percent of women who had unintended pregnancy (mistimed and unwanted)		43.6	42.3	44.2	44	NA

[a]Workgroups are listed in the order in which they were initiated.

[b]Information that is routinely collected via BRFSS but not included during year indicated.

CI = confidence interval

BRFSS = Behavioral Risk Factor Surveillance System

NA = not available

NM = New Mexico

HEDIS = Health Employer Data and Information Set

PRAMS = Pregnancy Risk Assessment and Monitoring System

BMI = body mass index

DTaP = diphtheria/tetanus/acellular pertussis

Hib = *haemophilus influenzae* type b conjugate vaccine

HepB = hepatitis B vaccine

MCO = managed-care organization

MMR = measles, mumps, rubella

screened for chlamydia by New Mexico's managed-care organizations—all of which are active participants in CPI—indicates progress in implementing this relatively recent prevention recommendation.

DISCUSSION

Promoting successful clinical prevention requires collaboration and coordination among many partners across the continuum of health services. On a micro level, clinicians provide the majority of preventive services while their office staff track and manage positive results. On a macro level, the public health community has expertise in assessing the value of CPS, prioritizing these services, and evaluating the success of population-based prevention programs. Administrators of clinics and health plans help improve CPS coverage by encouraging health professionals and support staff to make prevention an important component of routine clinical care and facilitating that task by providing performance feedback and incentives. Professional organizations provide content experts and help identify sources of funding for specific needs, such as surveys or educational campaigns. We believe that in planning CPI, the early inclusion of key partners from these different interest groups resulted in more complete and sustainable collaboration.

For development of prevention programs, state health departments have traditionally formed partnerships with universities, professional organizations, health-care facilities, or other government institutions by focusing on a specific disease or risk factor. Because CPS are largely delivered or coordinated by physicians, the early planners of CPI determined that an efficient model for a prevention initiative would be its integration into the principal organization representing physicians, the NMMS, which has a membership representing approximately 80% of physicians in the state. The timing for this collaboration was ideal in that NMDOH and NMMS leadership recognized the opportunity for a prevention-focused joint venture and that both organizations were willing to take responsibility for its success through funding and creating office infrastructure. Once support from the Medical Society and funding from the Health Department were attained, the CPI founders were able to convene providers, payers, policy makers, and public health colleagues to address the barriers to preventive services in a coordinated way. The partnership between the NMMS and the NMDOH has the added advantage and appeal of using and strengthening existing infrastructure, thus realizing substantial cost savings and efficiency over creating a new organization and bureaucracy. Though the tight-knit character of the public health and medical communities in New Mexico facilitated CPI's creation and growth, we believe that the department of health/medical society partnership is a model with potential application to larger and more complex jurisdictions than New Mexico.

Though CPI focuses on the clinical setting and is recognized in the state as a hub for coordination and expertise for CPS, its key public health partners with a population health perspective assure CPI's integration into a broader prevention framework for New Mexico. For instance, the Tobacco Use Prevention and Cessation workgroup is funded by NMDOH's Tobacco Use Prevention and Control (TUPAC) program to enhance the reach and efficacy of New Mexico's health professionals. This, in turn, allows TUPAC to focus more intensely on population-based initiatives such as public education, publicity campaigns, and promotion of clean indoor air initiatives. The Immunization workgroup complements a broader community strategy by participating in the New Mexico Immunization Coalition (NMIC). NMIC has broad statewide support and membership and is a prime conduit for dissemination of the Done By One program to parents, teachers, promatoras (lay health promoters), shot clinics, and community advocates. In addition, Healthier Weight Workgroup (HWW) members participate in a Prescription Trails initiative founded by a community active living coalition, a diabetes coalition, and the National Park Service. Prescription Trails is a program to facilitate and promote walking in urban areas in which maps of neighborhoods with walking paths and their features are described. The HWW will serve as a Prescription Trails liaison to clinicians, who will be provided with specific information about walking routes in the greater Albuquerque area and a Prescription for Health tool for referring patients to these resources. Finally, CPI members who are engaged in population health also serve to avoid duplication of efforts across organizations and present a more consistent message to patients and the public.

As the CPI has matured, the need to evaluate the workgroup activities and the larger coalition has grown. Evaluation of prevention activities and demonstration of their impact on health outcomes is challenging, especially for chronic diseases where the latency period between intervention and health outcomes is long and changes are only detected over many years of prevention efforts. In addition, the delivery of preventive services is influenced by many factors that compound the difficulty of ascribing a causal relationship between CPI activities and a change in provider behavior or in health outcomes. Nonetheless, some of the indicators

collected by CPI workgroups suggest improved delivery in New Mexico of several key CPS. The CPI has played a leadership role in promoting these preventive services and contributed to these improvements.

CONCLUSION

A powerful and dynamic partnership promoting clinical prevention has been achieved in New Mexico through an alliance of clinicians, public health, and health plans. The CPI has created a mechanism to more efficiently integrate evidence-based prevention into routine clinical practice and may serve as a model for other states or jurisdictions to enhance the reach and efficacy of prevention in caring for the patients and populations they serve.

The authors would like to acknowledge the helpful comments, suggestions, and encouragement of Drs. Jeff Harris and Doug Shensen and the contributions of the following Clinical Prevention Initiative members: Dr. Lynn Bryant, Dr. Lance Chilton, Dr. Ellen Cosgrove, Dr. Dan Derksen, Dr. Eve Espey, Dr. Carla Herman, Dr. Richard Hoffman, Linda Hubbard, Dr. Diana Koster, Dr. Michael Landen, Dr. Bruce Mann, Dr. Barbara McAneny, Dr. Steve Nickell, Dr. Tony Ogburn, Dr. Fred Pintz, Dr. Galina Priloutskaya, Dr. Bruce Trigg, Cynthia Rawn, Margy Wienbar, and Dr. William Wiese.

The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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